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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RUSSEL OLVENA TORRALBA** **11976 Stoney Peak Drive, #935** **San Diego, CA 92128** **Registered Nurse License No. 575494** Respondent.	Case No. 2013-299 OAH No. 2012100816 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about December 29, 2000, the Board of Registered Nursing issued Registered Nurse License Number 575494 to Russel Olvena Torralba (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed. On November 14, 2012, a Decision and Interim Order of Suspension pursuant to Business and Professions Code section 494, was issued whereby Respondent's license was suspended until the Board's final decision in this case.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 494 provides in part:

> (a) A board or an administrative law judge sitting alone, as provided in subdivision (h), may, upon petition, issue an interim order suspending any licentiate or imposing license restrictions ...
>
> ....
>
> (i) Failure to comply with an interim order issued pursuant to subdivision (a) or (b) shall constitute a separate cause for disciplinary action against any licentiate, and may be heard at, and as a part of, the noticed hearing provided for in subdivision (f) Allegations of noncompliance with the interim order may be filed at any time prior to the rendering of a decision on the accusation. Violation of the interim order is established upon proof that the licentiate was on notice of the interim order and its terms, and that the order was in effect at the time of the violation. The finding of a violation of an interim order made at the hearing on the accusation shall be reviewed as a part of any review of a final decision of the agency.

....

8. Section 726 of the Code states:

The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3.

....

9. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

....

(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

....

(b) Procuring his or her certificate or license by fraud, misrepresentation, or mistake.

....

(e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license.

....

REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would

have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

11. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

12. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTS

Golden Touch III

14. In August 2010, Respondent operated Golden Touch III, a residential nursing care facility, located in San Diego. G.K., a 91 year old patient, who suffered from severe medical conditions, was placed at Golden Touch III. G.K. had in place a tracheostomy collar and a Foley catheter, and needed wound care to the back of her hand, among other care needed. On August 20, 2010, G.K.'s doctor, visited G.K. at Golden Touch III to perform a routine examination. The doctor immediately noticed that the temperature in the facility was extremely high, and it was very hot and uncomfortable, particularly for elderly patients. There was also an awful odor in the facility as if none of the patients had been bathed.

15. The doctor discovered G.K. in a room in the back of the facility and she appeared to be in horrible pain. Although G.K. could not speak to her doctor, she appeared distressed which her doctor immediately recognized by the look in her eyes. The doctor examined her and discovered that her tracheostomy tube was not being adequately cared for because it was not operable and she was drowning in her own fluids. The doctor also observed a nasty wound on G.K.'s hand, which appeared to be neglected by the nursing staff. G.K. was sweating profusely due to the extreme heat in the room, and there were no fans or air conditioners that could be seen. When the doctor attempted to speak with the staff at the facility, the staff appeared to be unable to understand English. There was also another adult patient in another room in the back of the facility who was lying on his bed in a pool of sweat. This patient appeared to be bedridden and in distress.

16. Respondent arrived at the facility approximately twenty five minutes later and was immediately informed by the doctor that the conditions in the facility were unsafe, the temperature inside the facility was too high, and there was a lack of care being provided to G.K, who required 24-hour skilled nursing care. The doctor insisted that G.K. be transported by ambulance to a hospital for further care and then placed in an appropriate care facility. The doctor also insisted that the other adult patient, T.L., who was lying in a pool of sweat, be transferred to the hospital because he appeared to be suffering as well and required immediate medical attention. Respondent did not transfer the patients per the doctor's orders.

17. Three days later on August 23, 2010 and without improving the conditions of his facility, Respondent placed Nurse Alfredo in charge of providing medical care to the patients at Golden Touch III. Nurse Alfredo assumed the medical care of G.K. and T.L., both patients who required 24 hour skilled nursing or intermediate care, which were beyond the capability of Golden Touch III. Respondent did not have Nurse Alfredo review the physician's reports for either patient. On August 23, 2010, an investigator from the California Department of Social Services inspected Golden Touch III and discovered that Nurse Alfredo did not know the medical conditions of G.K. and T.L. and Nurse Alfredo also allowed a non-medical professional to provide medical care, including trachea suction and G-tube feeding. Nurse Alfredo also did not know where the diabetic supplies were located even though he was caring for a patient who required diabetic care. Both patients were non-communicative and had to be transported from the facility to a hospital by ambulance.

18. On or about April 10, 2012, pursuant to a Stipulation, Waiver, and Order in the disciplinary action entitled *In the Matter of Russel Torralba dba Golden Touch III Residential Care Facility* (CDSS No. 6510269401)*; Russel Torralba* (CDSS No. 6510263401B)*; Russel Torralba* (CDSS No. 6510263401C); *Russel Torralba* (CDSS No. 6510263401D); *Russel Torralba* (CDSS No. 6510263401E), the Department of Social Services, State of California revoked Respondent's license to operate a residential care facility for the elderly doing business as Golden Touch III, denied Respondent's applications to operate residential care facilities for the elderly at two locations, and revoked Respondent's administrator certificate for residential care

facilities for the elderly. Pursuant to the Order, Respondent shall not apply for, receive or hold any license or certification to operate any care facility including any community care facility, certified family home, residential care facility for the elderly, residential care facilities for persons with chronic, life-threatening illnesses or child care facility, for the balance of Respondent's life. Further, the Order provides that for the balance of Respondent's life, Respondent shall not be a member of a board of directors, an executive director or an officer of a licensee or an employee of a person licensed to operate a facility, shall not be present in a licensed facility or have contact with clients of a licensed facility.

Maria B.

19. In or about early 2011, Respondent and another registered nurse, Alfredo, were employed as registered nurses by AMS Homecare Solutions. In February and March 2011, Respondent and Alfredo were assigned to provide nursing care and treatment to Maria B., whose family contracted with AMS Homecare Solutions. In February 2011, Maria B., was a 98 year old disabled female patient, who required around the clock in-home medical care to treat a number of debilitating medical problems, including a stroke that resulted in the immobility of her right arm and leg, congestive heart failure, the need for a tracheotomy, and difficulty with speaking. However, she retained many of her cognitive abilities, including an awareness of her surroundings and recognition of family members.

20. In order to protect her property and ensure her safety, Maria B.'s family installed several video surveillance cameras throughout the home in 2008. Maria B.'s grandson installed two motion censored cameras in Maria B.'s bedroom, one camera which displayed close-up black and white footage of Maria B.'s bed and nearby surroundings, and one camera that provided an expanded view of the bedroom, which displayed colored footage. Both of the surveillance cameras in Maria B.'s bedroom were maintained in proper working order and recorded the activities of the nurses caring for Maria B.

21. The video surveillance cameras in Maria B.'s bedroom revealed that from February 27, 2011 to March 11, 2011, Respondent and Nurse Alfredo engaged in repeated lewd sexual acts with each other in front of and next to Maria B. Specifically, Respondent groped, fondled, and

stroked Nurse Alfredo's genitals multiple times within close proximity to Maria B.'s bed on February 27, 2011, February 28, 2011, March 3, 2011, March 4, 2011, March 8, 2011, March 9, 2011, March 10, 2011, and March 11, 2011. Maria B. was awake during many of these instances.

22. On March 3, 2011, Respondent exposed Nurse Alfredo's bare penis in Maria B.'s presence. On March 3, 2011 and March 11, 2011, Nurse Alfredo held Maria B.'s hand while Respondent groped and stroked Nurse Alfredo's genitals. During one of those incidents on March 11, 2011, Maria B. swatted her hand at Respondent and Nurse Alfredo, and appeared to be distressed by Respondent's sexual misconduct.

23. The video surveillance footage also showed that Respondent provided minimal nursing care to Maria B. and repeatedly ignored her. On more than one occasion, Respondent slept and watched television, instead of caring for Maria B.

24. On March 4, 2011, Respondent and Nurse Alfredo bathed Maria B. in front of an open window, exposing her nude body. On March 4, 2011, Respondent and Nurse Alfredo cleaned Maria B.'s trachea tubing using unsterile conditions. On March 7, 2011, Respondent and Nurse Alfredo covered Maria B.'s eyes for over thirty minutes and utilized a glove restraint on her left hand, even though Maria B. did not have physician orders for restraints.

25. Approximately two weeks after Respondent and Nurse Alfredo began caring for Maria B., Maria B.'s daughter received a report from a caregiver that Respondent and Nurse Alfredo had closed Maria B.'s bedroom door during the night. Maria B.'s daughter then watched the surveillance videos, depicting Respondent's sexual misconduct and lack of care for Maria B. Maria B.'s daughter immediately contacted AMS and asked that Respondent and Nurse Alfredo do not return and filed a complaint with the Board of Registered Nursing.

Interim Suspension Order

26. On October 24, 2012, at an Ex-parte hearing *In the Matter of the Interim Suspension Order Against Russel Olvena Torralva*, Case Number 2013-299, OAH Case Number 2012100816, an Interim Suspension Order Pursuant to Business and Professions Code section 494, was issued to Respondent, restricting him from working on the same shift in the same hospital as Alfredo [R.] and requiring Respondent to "notify his immediate supervisor before

every shift he begins that he is not permitted to work the same shift in the same hospital as Alfredo [R.]."

27. In October 2012, Respondent was employed as a registered nurse at Promise Hospital in San Diego. From October 25, 2012 to early November 2012, Respondent worked several nursing shifts at Promise Hospital in San Diego. At no point in time in October or November 2012 did Respondent notify his immediate supervisors at Promise Hospital that he was not permitted to work the same shift in the same hospital as Alfredo [R.], per the ISO. Respondent was terminated from his employment at Promise Hospital effective November 12, 2012.

Arizona Disciplinary Action

28. On or about January 22, 2013, pursuant to the Consent for Entry of Voluntary Surrender Order No. 1301008, in the disciplinary action entitled *In the Matter of Registered Nurse License No. RN092993 Issued to: Russel Olvena Torralba*, the Arizona State Board of Nursing (Arizona Board) accepted Respondent's surrender of his Arizona license and ordered that he not apply for re-issuance of the license for a period of five years.

29. In the Consent for Entry of Voluntary Surrender Order, Respondent admitted "the Board's Findings of Fact, Conclusions of Law." Respondent admitted that the Arizona Board received Respondent's application for renewal of license on or about May 14, 2012, in which Respondent answered "no" in response to the following question: "Since your last renewal, has disciplinary action or revocation been taken or is there currently a complaint, investigation, or disciplinary action pending against your CNA certificate, or any other health care or non health care related license or certification, in any state or territory of the United States?"

30. Respondent admitted that he failed to disclose that on or about April 10, 2012, pursuant to a Stipulation, Waiver, and Order in the disciplinary action entitled *In the Matter of Russel Torralba dba Golden Touch III Residential Care Facility* (CDSS No. 6510269401)*; Russel Torralba* (CDSS No. 6510263401B)*; Russel Torralba* (CDSS No. 6510263401C); *Russel Torralba* (CDSS No. 6510263401D); *Russel Torralba* (CDSS No. 6510263401E), the Department of Social Services, State of California revoked Respondent's license to operate a residential care facility for the elderly doing business as Golden Touch III, denied Respondent's

applications to operate residential care facilities for the elderly at two locations, and revoked Respondent's administrator certificate for residential care facilities for the elderly.

31. Respondent also admitted to that he violated A.R.S. § 32-1601(18)(a) (committing fraud or deceit in obtaining, attempting to obtain or renewing a license or certificate issued pursuant to the chapter), (d) (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public, (f) (having a license, certificate, permit or registration to practice a health care profession denied, suspended, conditioned, limited or revoked in another jurisdiction and not reinstated by that jurisdiction), and (g) (willfully or repeatedly violating a provision of the chapter or rule adopted pursuant to the chapter), and A.R.S. § 32-1061(22)(f) (having a license, certificate, permit or registration to practice a health care profession denied, suspended, conditioned, limited or revoked in another jurisdiction and not reinstated by that jurisdiction), and A.A.C. R4-19-403 (20) (engaging in fraud, misrepresentation, or deceit in taking a licensing examination or on an initial or renewal application for a licensure or certificate.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

32. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that Respondent was grossly negligent as follows:

a. Respondent repeatedly failed to provide nursing care to his patients at Golden Touch III which, under similar circumstances, would have ordinarily been provided by a competent registered nurse, when he accepted and retained patients G.K. and T.L. to his nursing facility, even though he knew or should have known that both patients required skilled nursing and medical services that were beyond the capability of Golden Touch III and that such admission was in violation of the licensing regulations; when Respondent refused to transfer residents G.K. and T.L. out of Golden Touch III upon the orders of a physician; when Respondent failed to have licensed and competent nursing staff at Golden Touch III to care for residents; and when Respondent failed to provide Nurse Alfredo with sufficient information to care for patients G.K. and T.L., including failing to inform Nurse Alfredo of the type of care that was required, failing

to provide him with sufficient history or physician orders and failing to orient Nurse Alfredo to the location of the nursing supplies, as is set forth in paragraphs 14 through 18 above, which are incorporated herein as though set forth in full.

b. Respondent repeatedly failed to provide care or exercise ordinary precaution which he knew or should have known could have jeopardized Maria B.'s health, when he engaged in sexual acts in front of Maria B.; when he slept during his shift instead of caring for Maria B.; when he failed to use aseptic technique while working with Maria B.'s trach; and by covering Maria B.'s eyes with a towel causing her distress, as is set forth in paragraphs 19 through 25 above, which are incorporated herein as though set forth in full.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

33. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that Respondent demonstrated incompetence as follows:

a. While providing nursing care to patients at Golden Touch III, Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse, when he admitted patients G.K. and T.L. to his nursing facility, even though he knew those patients required a higher level of care than could be provided at Golden Touch III and that such admission was in violation of the licensing regulations; when he failed to hire sufficiently trained staff to care for patients G.K. and T.L.; when he failed to provide adequate information for Nurse Alfredo to care for G.K. and T.L.; and when he failed to follow the orders of a physician who ordered the transfer of his patient, G.K., from the facility, as is set forth in paragraphs 14 through 18 above, which are incorporated herein as though set forth in full.

b. While caring for Maria B., Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse, when he failed to use aseptic technique while working with Maria B.'s trach; when he failed to close the blinds while bathing Maria B.; when he slept, used his cellular telephone, and watched television instead of caring for his patient; and when he engaged in repeated sexual acts next to and in front

of his patient, as is set forth in paragraphs 19 through 25 above, which are incorporated herein as though set forth in full.

THIRD CAUSE FOR DISCIPLINE

(Sexual Misconduct)

34. Respondent is subject to disciplinary action for unprofessional conduct under section 726 of the Code in that while on duty as a registered nurse, Respondent engaged in acts of sexual misconduct when he repeatedly committed lewd sexual acts next to and in front of an elderly patient, Maria B., as is set forth in paragraphs 19 through 25 above, which are incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

35. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a) of the Code in that while on duty as a registered nurse, Respondent engaged in unprofessional conduct as follows:

a. Respondent admitted patients G.K. to Golden Touch III in violation of licensing regulations and knowing that G.K. required skilled nursing services that were beyond the capability of Golden Touch III; Respondent failed to follow a physician's order to transfer patients G.K. and T.L. to a higher level of care as ordered; Respondent failed to hire sufficient, competent staff to care for patient G.K.; Respondent did not maintain a safe environment for patients at Golden Touch III; and Respondent allowed Nurse Alfredo to assume care for the patients at Golden Touch III without adequate supervision or information to properly care for the patients, as is set forth in paragraphs 14 through 18 above, which are incorporated herein as though set forth in full.

b. While Respondent was on duty as a registered nurse, Respondent repeatedly engaged in lewd sexual acts next to and in front of Maria B.; failed to close the blinds while bathing Maria B.; slept, used his cellular telephone and watched television instead of caring for Maria B., as is set forth in paragraphs 19 through 25 above, which are incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Disciplinary Action Against License to Operate Residential Care Facility for the Elderly)

36. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(4) in that on about April 10, 2012, pursuant to a Stipulation, Waiver, and Order the California Department of Social Services, Community Care Licensing, issued an order revoking Respondent's license to operate a residential care facility for the elderly doing business as Golden Touch III, denying Respondent's applications to operate residential care facilities for the elderly at two locations, and revoking Respondent's administrator certificate for residential care facilities for the elderly, as is set forth in paragraph 18 above, which is incorporated herein as though set forth in full.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with ISO)

37. Respondent is subject to disciplinary action under section 494(i) in that Respondent failed to comply with the Interim Suspension Order Pursuant to Business and Professions Code section 494, that was issued on October 24, 2012, which required Respondent to notify his immediate supervisor before every shift he begins that he is not permitted to work the same shift in the same hospital as Alfredo [R.], as is set forth in paragraphs 26 and 27 above, which is incorporated herein as though set forth in full.

SEVENTH CAUSE FOR DISCIPLINE

(Disciplinary Action Against Arizona Nursing License)

38. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(4) in that on about January 22, 2013, pursuant to the Consent for Entry of Voluntary Surrender Order No. 1301008, in the disciplinary action entitled *In the Matter of Registered Nurse License No. RN092993 Issued to: Russel Olvena Torralba*, the Arizona State Board of Nursing (Arizona Board) accepted Respondent's surrender of his Arizona license and ordered that he not apply for re-issuance of the license for a period of five years, as is set forth in paragraphs 28 through 31 above, which are incorporated herein as though set forth in full.

EIGHTH CAUSE FOR DISCIPLINE

(Disciplinary Action Against Arizona Nursing License)

39. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(b) and 2761(e) for procuring his Arizona nursing license by fraud, misrepresentation or mistake and making or giving a false statement or information in connection with the application for renewal with the Arizona Board, which is evidenced by his admissions in the Consent for Entry of Voluntary Surrender Order No. 1301008, as is set forth in paragraphs 28 through 31 above, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 575494, issued to Russel Olvena Torralba;

2. Ordering Russel Olvena Torralba to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: MARCH 14, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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